MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

SECOND INJURY FUND SURCHARGE
SECOND QUARTER

2nd Quarter 2006
April 1, 2006 - June 30, 2006
(Delinquent and Penalty due if received after July 30, 2006)

Commercial Insurance Carriers

(Please submit a separate form for each company.)

Company Name and Address:

NAIC # _____ **FEIN #** _____

Parent Company or Group Name and Address:

NAIC # _____ **FEIN #** _____

If there has been a name or ownership change in the past 24 months please indicate previous name(s) or owner(s):

NAIC # _____ **FEIN #** _____

Date this form will be sent:

1. New or renewed gross premiums for policies with 2006 inception dates
   Returned or refunded premiums for policies with 2006 inception dates -
   Net Premium =
   a. Multiply by 2006 Surcharge Assessment (3.0%) =

   New, renewal or additional gross premiums for policies with 2005 inception dates
   Returned or refunded premiums for policies with 2005 inception dates -
   Net Premium =
   b. Multiply by 2005 Surcharge Assessment (3.5%) =

   Additional gross premiums collected for policies with 2004 and prior inception dates
   Returned or refunded premiums for policies with 2004 and prior inception dates -
   Net Premium =
   c. Multiply by 2004 Surcharge Assessment (4.0%) =
2. Total lines 1a, b, & c = **Total Missouri Second Injury Fund Surcharge Due:** $0.00

3. If received by the Division after July 30, 2006, the payment is delinquent. Continue completing this form.

a. Enter amount shown in Item 2 (Total lines a, b, & c)
b. Late penalty, which is the **Surcharge Assessment Subtotal** x 0.5% +
c. Interest, which is the **Surcharge Assessment Subtotal** x 1.5% x _____ +
(number of months or any fraction of a month delinquent)

4. Add lines 3a, b, & c = **Total Missouri Second Injury Fund Surcharge w/ Penalty & Interest Due:**

Name of person completing form | **E-mail Address** | **Phone Number** | **Date**

I hereby certify that this application contains no willful misrepresentation or falsifications and that the information provided is true and complete to the best of my knowledge and belief.

Signature - Pres./Exec. Officer | **Printed Name** | **Title** | **Date**

Mail one copy of this form and a check made payable to:
Missouri Division of Workers' Compensation, Attn: Second Injury Fund, P.O. Box 58, Jefferson City, MO 65102-0058

(Mail this copy even if no money is due at this time.)

Keep one copy for records.